UNITED STATES DISTRICT COURT
DISTRICT of MINNESOTA

The Estate of Gene B. Lokken, The Estate of Dale Henry Tetzloff, Glennette Kell, Darlene Buckner, Carol Clemens, Frank Chester Perry, The Estate of Jackie Martin, John J. Williams as Trustee of the Miles and Carolyn Williams 1993 Family Trust, and William Hull, individually and on behalf of all others similarly situated, Plaintiffs, vs. UnitedHealth Group, Incorporated; UnitedHealthcare, Inc.; naviHealth, Inc.; and Does 1-50, Defendants.	File No. 23-cv3514 (JRT/SGE) Minneapolis, Minnesota August 29, 2024 2:05 p.m.

BEFORE THE HONORABLE JOHN R. TUNHEIM
UNITED STATES DISTRICT COURT JUDGE

(MOTIONS HEARING)

Proceedings reported by certified court reporter; transcript produced with computer.

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P R O C E E D I N G S

IN OPEN COURT

THE COURT: Good afternoon. This is Civil Case Number 23-3514, Estate of Gene Lokken vs. UnitedHealth Group, and there are additional plaintiffs and defendants.

Counsel, would you note appearances this afternoon, first for the plaintiffs.

MR. ASP: Good afternoon, Your Honor. David Asp from Lockridge, Grindal, Nauen for the plaintiffs.

MR. DANAS: Glenn Danas from Clarkson Law Firm in Malibu for plaintiffs.

MR. WALLER: Derek Waller, also Lockridge, Grindal, Nauen, for plaintiffs.

MS. BOELTER: Michael Boelter from Clarkson Law Firm for plaintiffs.

MS. GORDON: Emma Ritter Gordon from Lockridge, Grindal, Nauen for plaintiffs.

THE COURT: All right. Good afternoon to all of you.

For the defense?

MR. PAPPAS: Good afternoon, Your Honor. Nicholas Pappas of Dorsey & Whitney for the defendants. I'm joined by Shannon Bjorklund, Nicole Engisch, and Michelle Grant.

THE COURT: All right. Good afternoon to all of

you.

All right. The Court has read the briefs on this motion to dismiss today. So are you going to proceed, Mr. Pappas?

MR. PAPPAS: Thank you, Your Honor.

THE COURT: Go ahead.

MR. PAPPAS: May it please the Court.

There are two key issues in dispute on the motion to dismiss today: First, whether Medicare Part C preempts plaintiffs' state law causes of action; and, second, whether plaintiffs' admitted failure to exhaust administrative remedies can be excused either because they do not arise under Medicare or because exhaustion can be excused under *Mathews vs. Eldridge*. The Court can rule on either of these issues; and if it does so in our favor, the case should be dismissed.

I'll start with preemption. Plaintiffs are or were members of Medicare Advantage health insurance plans purchased from the defendant -- from the defendants. Plaintiffs allege seven causes of action. They allege in their claims that they were entitled to coverage for the cost of staying or staying longer in skilled nursing facilities.

They claim defendants conducted insufficient investigation into their individual medical histories by

clinicians in favor of artificial intelligence decisions. They claim, therefore, they were denied benefits, all in violation of state common law and statutory duties.

They assert common law claims for breach of contract, breach of the implied covenant of good faith and fair dealing, unjust enrichment, and various insurance bad-faith statutes.

We assume these factual allegations solely for purposes of this motion, but, Your Honor, it's -- we want to state for the record the defendants strongly deny that artificial intelligence is used in place of individual decisions by clinicians. That's not for the Court to decide today, but wanted that clear for the record.

All of these claims, Your Honor, and the substantive underpinnings of these claims are governed by Medicare standards, including the administration of Medicare Advantage plans by Medicare Advantage organizations and the determination of patients' coverage for insurance benefits.

As we discussed in our papers, in deciding the motion to dismiss based on Medicare preemption, the task for this Court will be to apply the Medicare Act's express preemption provision.

And most importantly, Your Honor -- the plaintiffs don't get to this until well into their brief, but this is, we think, critical for this Court -- the preemption

provision states, quote, standards established under Medicare shall supersede any state law or regulation with respect to MA plans.

That is as broad as it sounds, Your Honor, and there's case law that we've cited to the Court regarding what "any state law" means, what "with respect to" means, and what "standards established under Medicare" means.

THE COURT: The Eighth Circuit test appears, at least on its face, to be a little different than what other circuits are developing on preemption.

MR. PAPPAS: Your Honor, Your Honor is focused on the *Wehbi* case. We respectfully view the *Wehbi* case as being no different than the Ninth Circuit case. And the *Wehbi* case, Your Honor, cites favorably to all of the cases that we cited in our brief, and those cases -- and even quotes those cases as the underlying conduct rationale and the same subject matter rationale, which is what the Eighth Circuit articulated.

The same subject matter and the underlying conduct is exactly the rationale the Ninth Circuit used in *Uhm*. And in *Do Sung Uhm* the Ninth Circuit likewise, you know, adopted a very broad standard.

I think the reason the Eighth Circuit's decision in *Wehbi* came out differently on some of the claims there was because of the context in which the Eighth Circuit was

ruling. And in that case the context was Medicare Part D and the application of whether Medicare Part D standards apply to PBMs, pharmacy benefit administrators. So it's important to keep that context in mind, Your Honor, because the PBM is one step removed from the actual patient experience.

Our case involves that direct patient experience; and the regulations of the Secretary focused precisely on the direct patient experience, the medical necessity of the services, the duration of the stay at the skilled nursing facility, all the things that are the essence of what Medicare is, which is the delivery of healthcare to our seniors.

So Your Honor is right, and the plaintiffs have argued, that the *Wehbi* case is different from *Do Sung Uhm*; and we believe that a close reading would suggest otherwise.

And if Your Honor wouldn't mind, I would like to focus on *Do Sung Uhm*, because we view that case as being precisely and directly on point. It's on point because that case involved a member or an enrollee claiming denial of benefits under state law, and the Ninth Circuit exhaustively analyzed a common law cause of action and a statutory cause of action and found both were preempted. And as I said, the Eighth Circuit cited that case with approval in *Wehbi* and we think, therefore, agreed with it for all practical purposes.

So, as I mentioned earlier, the Ninth Circuit starts by saying that the task of the court is to, quote, identify the domain expressly preempted. We view that language as being similar to the same subject matter standard. And further the court said the task is to look at the underlying conduct, again, language that the Eighth Circuit cites. So looking at the subject matter and the underlying conduct, the court found preemption.

Importantly, the court also analyzed the "with respect to" language and how the "with respect to" language came about, as well as the other language in the statute. And the Ninth Circuit focused on the amendment to the preemption provision in 2003, which everyone would agree expanded the applicability of preemption.

In that context the pre-existing amendment, which is quoted in *Do Sung Uhm*, required specific conflict and required that the underlying state law apply to four specific categories. Those were eliminated. So now a conflict isn't even required. It's so long as any state law applies, even to the same conduct, or outside of the four specific categories would be preempted, and we think that's very important to give the Court a sense of the breadth of Medicare preemption here.

Your Honor, I would like to now explain what are the applicable Medicare standards. We cited those in our

papers at page 17 to 18. They're very dense. I won't repeat the citations, but it's important for the Court to focus on the breadth of the Medicare standards applicable here and how they relate to plaintiffs' state law claims.

So the parties all agree that the plaintiffs here purchased Medicare Advantage plans and that such plans are governed by Medicare Part C.

Medicare Part C is a private insurance policy that is intended to provide the same Medicare benefits that traditional Medicare has. The parties all agree that the Medicare Advantage plans, therefore, are governed by strict procedural rules and rules requiring maximum -- and require coverage.

Importantly, Medicare Part A governs medically necessary skilled nursing and rehabilitation care and covers up to 100 days of skilled nursing in rehabilitation care for a benefit period following a qualified inpatient hospital stay of at least three days, subject to certain conditions.

So the statute itself gives you the maximum benefit of 100 days in a skilled nursing facility, but under what conditions, Your Honor? The conditions are -- again, this is in the statute -- are that the patient must require skilled nursing or skilled rehabilitation services daily. The daily skilled services must be services that, as a practical matter, can only be provided in a skilled nursing

facility on an inpatient basis. The services must be provided to address a condition for which the patient received treatment during a qualified hospital stay or that arose while the patient was receiving care in a skilled nursing facility. That's at 42 U.S. Code 1395f(a)(2)(B). Again, it's in our papers, Your Honor.

Congress delegated broad rule-making authority to the Secretary of HHS to further elaborate on these general standards. How do you determine whether daily care is required? How do you determine what is the nature of the care? What is the conditions for which the patient received services in the hospital prior to going to the skilled nursing facility? And that's at 1395w-26(b).

So under that broad rule-making authority, the Secretary adopted regulations governing plan benefit determinations, and that's at 42 C.F.R. 422.566 through 422.576. I won't quote those further, Your Honor, but those regulations deal with things like pre-admission and admission requirements, level of care requirements, criteria and the need for skilled services, examples of skilled nursing at rehabilitation services provided in the regs, limitations on the amount of benefits, and requirement for post-hospital care.

The required investigation into medical necessity is also addressed, and this is the most important one,

Your Honor, the one that we think directly is covered by the plaintiffs' claims here. Most -- the regulations clearly provide that an adverse coverage determination must be reviewed by a physician or other appropriate healthcare professional, and that's 42 C.F.R. 422.566(d).

So the plaintiffs' claim that AI is used rather than physicians would directly violate a Medicare regulation. It doesn't happen, Your Honor, as I said earlier, but that's not for the Court to decide today. We're assuming that it does happen. But it's already covered. It's already illegal under the Medicare regulations.

Similarly, Your Honor, federal regulations require Medicare Advantage plans to have written utilization management policies and procedures that allow for individual medical necessity determinations.

The Secretary has, in fact, recently this year published frequently asked questions specifically approving the use of algorithms and AI to assist in making coverage determinations.

So while AI may be used to assist, Your Honor, the Secretary has not said that you can simply have AI make the decision. The physician has to make the decision, but AI can be used.

So the point of this, Your Honor, the regulations

of the statute already deal with the issue of how AI can or cannot be used in the context of determining lengths of stay and the medical necessity for skilled nursing services.

So going back to *Do Sung Uhm*, Your Honor, in addition to dealing with the legislative history and the interpretation of the words "with respect to," the court also focused on the interpretation of "any state law or regulation" and the court said by using "any," the court distinguished the Medicare preemption provision from the Boat Safety Act, which plaintiffs have cited to as being somehow analogous.

The Boat Safety Act used "a state law" and interpreted that to only refer to statutory claims rather than common law claims, and the Ninth Circuit said, well, no, the word "any" makes a difference and because Congress used the word "any," it's a broader preemption provision. And I think, interestingly, because the Eighth Circuit cited to the *Uhm* case, we think the Eighth Circuit likewise adopted that broader interpretation.

So in opposition to our motion to dismiss, the plaintiffs argued that "any state law" does not include common law claims, and I've addressed that already.

They rely on other non-Medicare cases, which we've addressed in our papers, so I won't deal with that today, Your Honor.

We've already talked about *Wehbi*, so, Your Honor, unless Your Honor has any further questions on *Wehbi*, I'll skip through all of that.

And I think where that leaves me is the exhaustion argument, Your Honor, exhaustion. So exhaustion is an alternative ground. It's -- we put it in there. The plaintiffs basically don't even dispute that none of the plaintiffs here went through all levels of exhaustion, but they nevertheless seek to excuse the plaintiff from exhaustion on two grounds:

One, that the plaintiffs' claims don't, quote, arise under the Medicare Act and "arising under," for purposes of Medicare, is somehow similar to the "with respect to" analysis, Your Honor.

To the extent that a claim -- let's see. Yeah, Your Honor, to the extent the plaintiffs' claim is, quote, inextricably intertwined with a benefit determination, even though it's brought under state law nomenclature, the courts have held that that nevertheless is a claim that arises under the Medicare Act.

And we believe there's no question but that the plaintiffs' claims deal with benefit determinations and coverage determinations. In fact, Your Honor, Counts I and II of the Complaint are brought on behalf of a class they've named the benefit denial class.

They've cited in their papers their alleged monetary losses being their out-of-pocket expenses for paying for the skilled nursing facilities. So when the plaintiffs lost coverage under the Medicare Advantage plan, some of the plaintiffs stayed in the skilled nursing facility and paid out of pocket. So they're seeking reimbursement of those funds. Well, that is equivalent to the benefit determination.

But putting aside their direct claim for benefits, which we think the Complaint suggests they are asserting, all of their claims are predicated and intertwined with the loss of coverage. All of the alleged failure to investigate, the bad-faith insurance claims are all predicated on you improperly denied me benefits, you denied my stay and caused me to leave because you didn't investigate individually, you used AI.

For all those reasons, Your Honor, we think it's quite clear that the plaintiffs' claims arise under because they're inextricably intertwined.

THE COURT: So the evaluation of the Medicare Act for resolution here would involve the regulations that determine how you define benefits? Is that what your argument is, that the arising under or with respect to the Medicare Act would implicate the regulations and how you're supposed to evaluate claims? Am I --

MR. PAPPAS: That's correct.

THE COURT: -- accurate about that?

MR. PAPPAS: The regulations in the statute itself, Your Honor, the -- how one evaluates claims is what in the healthcare world is called utilization review. Is the medical service medically necessary, right? And that is extensively regulated by the regulations.

THE COURT: Do the terms of the insurance contract matter?

MR. PAPPAS: The terms of the insurance contract matter to the extent that they only bolster the point that the Medicare regulations apply. We gave the Court excerpts for those. But that's all they say.

It's very clear that everyone knew from the very beginning your Medicare Advantage contract is intended to replicate the benefit that you would get under traditional Medicare and that the regulations apply, and there's other terms and conditions there. I don't think the Court needs to construe the plan in any way other than that. It's purely for informational purposes that we gave the Court that information.

Now, the plaintiffs say, well, we don't seek benefits here, so therefore there's no inextricable intertwining, right? This isn't a claim for benefits. We disclaim benefits, right?

Your Honor, the cases have dealt with that. The cases make clear that that's not dispositive. Again, we cite the *Uhm* case, but there are other cases, *Kaiser vs. Blue Cross of California*, *Shalala vs. Illinois Council on Long Term Care*. We cite those in our papers.

The *Heckler vs. Ringer* case from the U.S. Supreme Court likewise makes clear that the court is to look behind the pleadings and look to what is, at bottom, the plaintiffs' claim.

In *Heckler vs. Ringer*, it was an injunctive relief case. There was no claim for benefits and the court described the plaintiffs' claim in that case as a disguised claim for benefits, that the plaintiffs really were complaining about I didn't get my benefit, right?

And the plaintiffs here are saying, well, you used AI and that's the problem. Well, the only relevance of using AI is they claim some denial of benefits. So in the same way that *Heckler vs. Ringer* was a disguised claim for benefits, so is the plaintiffs' claim here; and it's not even so disguised, as I mentioned earlier, Your Honor.

The other ground on which the plaintiffs are seeking to avoid exhaustion here, Your Honor, is that the exhaustion should be excused on the grounds of -- set forth in *Mathews vs. Eldridge*.

We've cited the Court to another Supreme Court

case, *Califano vs. Sanders*, which we were surprised that plaintiffs didn't even cite to the case in their opposition. But *Califano vs. Sanders* makes clear that *Mathews vs. Eldridge* applies only where a claim is brought alleging constitutional violations.

And in that case the court said, well, of course if you are alleging denial of constitutional rights, there will be a federal court remedy available to you. We're not going to require you to go back to the administrative agency and assert a constitutional claim, which is going to be decided by a court anyway.

Plaintiffs haven't asserted a constitutional claim, Your Honor. So based on that, under *Califano vs. Sanders*, the plaintiffs cannot use *Mathews vs. Eldridge* to excuse exhaustion.

But even under *Mathews vs. Eldridge*, Your Honor, if the Court applies the *Mathews vs. Eldridge* standards, the -- in that case you have to have the claim being collateral to a claim for benefits. You have to have irreparable harm and futility. Each of those -- we laid this out in our papers. Each of those requirements are not met here.

Whether post-acute care was medically necessary, whether AI was used and that complies with Medicare regulations or the use of utilization management policies,

these are all at the heart of claims for benefits, as I mentioned earlier, Your Honor. So they don't meet the first standard of a collateral matter.

In terms of irreparable harm, courts have routinely held that a delay in the payment of benefits that arises from exhaustion is not irreparable harm, and therefore they don't meet that standard either.

And, finally, there's no evidence and they can't show that exhaustion would be futile. In fact, some of the plaintiffs themselves succeeded in their administrative appeals for denial of benefits and some of them are still pursuing administrative claims.

Ms. -- Plaintiff Lokken and I don't remember the other one, but there's another plaintiff whose claims are ongoing.

There's a third plaintiff who her claims -- or his claims were ongoing at the time of the Amended Complaint, although the time has expired. If tolling applies, that plaintiff will also potentially have an administrative remedy.

And, likewise, even the plaintiffs that didn't pursue any administrative appeals can seek excusal from the Secretary of statutory deadlines and regulatory deadlines.

So all of the plaintiffs could have and certainly some even today can assert administrative claims. So

there's no way the plaintiffs are going to be able to show that exhaustion would be futile.

And unless the Court has any questions, that's what I have today.

THE COURT: That's fine. Thank you, Mr. Pappas.

Mr. Asp.

MR. ASP: Thank you, Your Honor.

The defendants' position on Medicare preemption would lead you to error because it does not follow the Eighth Circuit's decision in *Wehbi*, which talks about how the Court should apply Medicare's preemption clause to state claims.

The defendants have the burden to prove preemption, which means that they have the burden to set forth the test. And under *Wehbi* what that means is that they need to set forth the specific state law requirements that they say are displaced and then apply the specific federal statute or regulation that displaces them.

Instead of doing that here, what they've asked you to do is to say that basically because this is covered by Medicare or governed by Medicare, that the state laws are preempted. That would be an error.

Now, the response today and in the briefing is that defendants believe that the Eighth Circuit in *Wehbi* adopted the standards in the -- that they cited in their

opening brief. *Wehbi* wasn't cited in defendants' opening brief. They were out-of-circuit cases.

And we heard again today the claim that all of the cases that they cited were cited by *Wehbi* or that we argued about were cited by *Wehbi*, and that's not true. Three of them were. The rest were not, including the California Supreme case -- Supreme Court case that they rely heavily on in their opening brief. It's also important to look at how *Wehbi* cited those cases.

It's not true to say that *Wehbi* adopted the Ninth Circuit's approach. The *Uhm* case, which my colleague mentioned, was a cf. cite at the end of a paragraph on page 971 of the opinion for the proposition that standards in the preemption clause refers to statutes and regulations. Nowhere does the Eighth Circuit say we followed the Ninth Circuit's approach in this case. In fact, the Eighth Circuit does say we're creating a framework for considering Medicare preemption. So the Eighth Circuit is doing something different.

If that's not clear from the case itself, which we think it is, you can look at the Tenth Circuit's decision in *Mulready*, which we cited in our response brief and was not in the reply. In that case the Tenth Circuit acknowledges that the Eighth Circuit is doing something different. The analysis is more narrow in the Eighth Circuit than it is in

the Ninth Circuit, the First Circuit, and the other cases that were cited in the defendants' briefing.

So the question is how do you apply *Wehbi*, the Eighth Circuit's framework, here. I think there's three things you can draw from the standard described by the Eighth Circuit:

First, as noted in the opinion, as I just mentioned, the term "standards" means statutes and regulations.

So one of the things the defendants have cited to are policy guidance, including a frequently asked question about the use of AI. That can't preempt state law. The only things that can preempt it are the statute or the regulation.

THE COURT: Where is the claim that AI was used coming from here? Is this -- I mean, I understand, I think, what the defense is saying, that it can be and properly used as a part of an evaluation tool, but it's still a doctor making the decision. Is this -- this isn't farmed out to AI, is it? Or where is this coming from?

MR. ASP: Our allegation is that it is. And the allegation is that the doctors, the medical directors are pressured to follow the AI recommendation, which is artificially low. If they don't follow it, they are punished. And as a result, almost all of the claims are

overturned on appeal because they're not actual medical necessity determinations, they're the algorithm's determinations.

THE COURT: I see. Okay.

MR. ASP: And that's kind of an important issue because -- and I will kind of jump to this. When he does -- when they do cite to the specific standards, the one that I think he emphasized here today was one that says that a physician has to make a medical necessity determination.

And that is in the regulation, but the regulation is broad. It doesn't say what happens when the physician is pressured to ignore their professional judgment and follow the algorithm, for example, or they have to do it or face punishment. Those are the things that we've alleged here, and that's the classic kind of bad-faith conduct that states typically regulate.

So if you look at what *Wehbi* says at page 971, it talks about again the preemption provision. It defines the term "supersede" to mean displace. So the Medicare statute applies to preempt state laws that are displaced by Medicare.

And the way that *Wehbi* does that analysis is looks at every particular state law in North Dakota, in that case, and then says how is this actually displaced. You can't just say it's government Medicare; it has to be displaced.

So -- and, notably, the Eighth Circuit also said that when a federal rule uses highly general language, it leaves the specific regulation to the states. So it doesn't mean the state can't regulate at all in an area. It means that it's acknowledging the state is regulating that area.

And that's a very important point because we cite to the Medicare Managed Care Manual. This is in footnote 6 of our brief. And the agency says other state health and safety standards or generally applicable standards that are not specific to health plans are not preempted. So that's the agency telling you that if it's generally applicable, it wouldn't be preempted.

It's also important here, I think one of the points this morning -- I don't know if it was in the briefing, but I heard the defense make here -- is that while the *Wehbi* case involved PBM regulation, that's a different type of regulation because it's -- I think the language used was doesn't -- not about the direct patient experience, but about the conduct of PBMs.

But, to me, that's more likely to be preempted than the state common law because in North Dakota they're passing a particular law governing the conduct of PBMs as it relates to Medicare and they're saying that's not preempted. They're unsatisfied with the federal regulation doing more.

Here we're talking about generally applicable

state laws that historically have applied to insurance company conduct when they're looking at -- when they are deciding claims in bad faith. Those wouldn't be preempted. It would be allowed to proceed.

And so just a couple more points on the analysis from *Wehbi* is that if you look at the actual way that it applied -- there, for example, is a North Dakota statute on conflict of interest with PBMs. There also was a Medicare standard on conflict of interest.

So the Eighth Circuit is looking at that and saying, well, that subject matter doesn't mean that the state law -- the fact that it's the same subject matter doesn't mean that it's preempted. It just means the state and federal laws are doing similar things. It's not displacing the area; it's just similar.

And we'd argue that's the same time thing here. We're using generally applicable state laws to govern insurance company conduct in handling claims, even if those claims are separately regulated by Medicare.

We think that when you apply *Wehbi* and look at it as it applies to the claims here, actually as the court would instruct you to do, you will find that they're not preempted.

So with -- on the exhaustion issue, I want to be clear about the framework that we're dealing with here. If

you conclude that it doesn't arise under the Medicare statute, that our claims don't arise under Medicare, then the analysis is finished. You wouldn't go down the line to consider whether there's a waiver on exhaustion of remedies.

So I think the way the courts describe it, and I think the *Ringer* case is what defendants have relied on, it talks about: At bottom, is this really a claim for benefits? Are you saying with your declaratory judgment or whatever other claim you have, that at the end of the day you want to recover benefits here?

And that's not this case. That's not what we're asking about. Our objection is to the way that they are using AI to handle claims as they're being considered or as they're determining -- making medical necessity determinations, regardless of whether that results in a claim of approval or not. It's not a claim for benefits.

If we prevail on this case, it's possible that claims could go back through the process and still be denied for a separate reason. We don't get automatic approvals, as they were talked about in *Ringer*. This is about the conduct in deciding claims.

So we think that makes it distinguishable. That should lead you to conclude that it doesn't arise under Medicare and, as a result, the exhaustion -- or the exhaustion of administrative remedies requirement wouldn't

apply.

If you conclude that it does apply, that it does arise under Medicare, then we'd say the exhaustion requirement is waived. And that analysis has been discussed by the Eighth Circuit several times and none of those cases that we cite by the Eighth Circuit, including cases like *Schoolcraft* or *Mental Health Association of Minnesota*, none of those cases say that waiver of exhaustion is only available to constitutional claims. That's not the law.

Now, they criticized us for not citing the *Califano* case. I think if you look at that case, you will see that what the Supreme Court is doing is not setting forth a rule that says it only applies to constitutional claims. It's recognizing that when there are constitutional claims, the exhaustion requirement might not apply, but it is not limiting the cases in that way. And that's how you read the case so it's consistent with the Eighth Circuit case law. They're not citing the case that says -- in the Eighth Circuit that has that rule.

Just as a sort of -- this didn't come up yet, but one of the issues in the briefing was about the presentment requirement, and that is a nonwaivable subject matter jurisdiction requirement.

All of the claims here were presented in that they were initially submitted or, if there was a denial, there

was an initial appeal. So we did satisfy the presentment requirement, which is the only piece that goes to nonwaivable subject matter jurisdiction. And the best case to look on that in the Eighth Circuit, I think, is *Mental Health Association of Minnesota*, which talks about what that requirement means.

Another issue before I get to the exhaustion analysis: The defendants had made this argument, that claims have to be submitted to the Secretary, not a managed care organization, even though all the other functions are delegated to that organization.

I think that analysis is incorrect, and the best way to respond to that is to look at the Ninth Circuit's decision in a case called *Global Rescue Jets*. That's 30 F.4th 905. It talks about why submitting a claim to the MAO is sufficient for -- to present the claim.

So with respect to the three factors on whether to waive the exhaustion requirement, I think these claims are collateral because -- and if you look again at *Schoolcraft*, at *Bowen*, the Supreme Court case, those cases have a similar situation, where those cases actually were enforcing federal regulations and saying we -- it doesn't do us any good to appeal these on a claim-by-claim basis. Because you've enacted some type of policy on a broader scale, as we have here, that means that those -- we can't get relief on an

individual basis. So it's not collateral. We're arguing about what they've done with the claims process, not a particular claim.

It also is absolutely the case that we're looking at both irreparable injury and futility here. I really don't think there can be an argument any other way. In the briefing, as I read it, the defendants have essentially tried to rewrite our Complaint so that all we're complaining about is individual claims for benefits and we owe money.

But if you look at the allegations in the Complaint and then compare them to these Eighth Circuit cases, you will see these are exactly the types of circumstances where there is irreparable injury and there's futility in continuing to process. And let me just give you a couple of examples.

One of our clients is Frank Perry. That's at paragraphs 136 and 137. He had ongoing health issues due to ongoing denials. The denials would appear two days after the appeal was decided. So he would appeal, but then get a new denial over and over again. He suffered longstanding health damage, not just financial damage, but longstanding harm due to the defendants' use of AI.

Jackie Martin -- this is 140 to 150 -- received weekly notices of noncompliance, even after his appeal succeeded. So appeals -- the appeal is totally futile. You

win the appeal. They continue to tell you they're denying the claim. That happened through naviHealth, by the way, even after someone at UnitedHealth told him that the claim should be covered. So he's just continually running into this issue over and over. It is a fundamental problem with how it was being handled. Eventually he stopped treatment, left, and died. So he suffered irreparable injury.

The plaintiffs here suffered irreparable injury that's not just money, and it is futile for them to continue to appeal. They can't address the ultimate issue here. So if there is an exhaustion requirement that applies, it should be waived here.

Thank you.

THE COURT: Thank you, Mr. Asp.

Did you have a brief reply, Mr. Pappas?

MR. PAPPAS: Briefly, Your Honor.

First, Your Honor, going back to *Wehbi* or web-ee, however you pronounce it, it's important for the Court to recognize that PBMs have historically been regulated by the states. And I don't think the plaintiff can say, notwithstanding that there are these insurance bad-faith statutes, that these types of claims are in the area of state regulation.

These types of claims are claims relating to Medicare Advantage insurance. It's a creature of federal

statutes and a federal benefit. There's no question that Medicare has -- prior to Part C coming into play, these people were all governed by Medicare. So going all the way back to the '60s, you had the Medicare statute and Medicare regulations. So there's no similar historical regulation by the states in these specific types of areas.

In terms of -- I heard counsel argue that when -- the state laws are doing similar things to the federal laws and therefore can't be preempted under that circumstance.

We cite the case *Aylward*, Your Honor. In the *Aylward* case -- it's a Ninth Circuit case -- the court cites to the ERISA body of law making clear that preemption exists even where the states are purporting to do something similar to the federal statute because they may impose different remedies and therefore undermine the national uniform scheme that Medicare is intended to capture.

And the language of the court in the *Aylward* case was that Medicare preempts state law when a state law duty parallels, enforces, or supplements an express federal MA standard on the subject.

So to some degree that's what's happening -- that's what the plaintiffs are arguing here. They're saying, well, you know, state law will further the federal interest, but the federal interest doesn't provide the types of remedies that state law would provide and therefore are

preempted.

Further, Your Honor, in terms of whether exhaustion should be required here, the plaintiffs did in some cases seek to exhaust. They brought claims for benefits. I understand one of the plaintiffs even challenged the use of AI.

There is a way to bring that claim, the plaintiffs' claim here, to the Secretary. We argued in our papers that the Secretary is actually the proper defendant here if they wish to make that claim.

405(g) of 42 U.S. Code, which is what creates jurisdiction for the Court to look at, review Secretary determinations, requires, as a predicate to the Court having any jurisdiction at all, that there be a final determination by the Secretary.

The plaintiffs claim here that AI is used to automatically deny care in the place of a physician. It's not been brought to the Secretary and therefore the Court has no jurisdiction absent that being exhausted and reviewed in accordance with the statute. There's no reason that plaintiffs can't do that.

Califano, Your Honor, I -- with respect to counsel, I think he is completely misreading the *Califano* case. The *Califano* case did not simply affirm that if there's a constitutional claim, that that is a collateral

claim. The Supreme Court was considering whether or not exhaustion should be excused and said it should not in that case because there was no constitutional claim.

That's exactly our case. There's no constitutional claim; therefore, exhaustion cannot be excused when the claims are covered by or arise under the Medicare statute.

In terms of presentment, Your Honor, we looked for it. There's no case cited in the plaintiffs' papers. The one case they did cite, saying that you can somehow present to the Medicare Advantage organization rather than to the Secretary, had to do with a completely different context, federal officer jurisdiction.

Well, surely in removing a case from state court to federal court you can remove if the Medicare Advantage plan is sued and therefore there could be federal officer jurisdiction.

That is a far cry from saying that the Medicare Advantage plan is the Secretary for purposes of 42 U.S. Code 405(g). 405(g) is very clear that the Secretary's final determination is what this Court has jurisdiction to review in a claim arising under the Medicare Act.

Thank you, Your Honor.

THE COURT: All right. Thank you, Mr. Pappas.

Did you have anything else, Mr. Asp?

MR. ASP: No, Your Honor.

THE COURT: Okay. Thank you.

Thank you, Counsel, for arguments today. Very helpful. The Court will take the motion under advisement. We'll issue a written order as quickly as possible. Thank you.

Have a good weekend, everyone.

(Court adjourned at 2:49 p.m.)

* * *

I, Lori A. Simpson, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

Certified by: *s/ Lori A. Simpson*

Lori A. Simpson, RMR-CRR